IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals
(Before Fitzgerald, P.J., Neff, J.J., and White, J.J.)

MICHIGAN CHIROPRACTIC COUNCIL and the MICHIGAN CHIROPRACTIC SOCIETY,

Petitioners/Appellees,

v

COMMISSIONER OF FINANCIAL AND INSURANCE SERVICES,

Respondent,

and

FARMERS INSURANCE EXCHANGE and MID-CENTURY INSURANCE COMPANY,

Intervening Respondents/Appellants.
_____/

Supreme Court Nos. 126530 and 126531

Court of Appeals Nos. 241870 and 241874

Ingham County Cir. Ct. No. 01-93481-AA

APPELLANTS' REPLY BRIEF

THE APPEAL INVOLVES A RULING THAT A PROVISION OF THE CONSTITUTION, A STATUTE, RULE OR REGULATION, OR OTHER STATE GOVERNMENTAL ACTION IS INVALID

ORAL ARGUMENT REQUESTED

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INTRODUCTION

MCC/MCS suggest throughout their brief that the PPO Option fails to meet Farmers' obligations to provide all reasonably necessary services to insureds. (MCC/MCSs' Br at 6, 7, 29.) They argue that Farmers retains the right to determine the "appropriateness" of care and allege, without support of any kind, that various factors could result in an insured being unable to obtain necessary services from PPOM. (MCC/MCSs' Br at 6, 7, 29.) This argument is absurd. As the Insurance Commissioner recognized, "the PPO Option neither expands nor diminishes the risks purported to be assumed in the general coverage of the policy *because those risks are established as a matter of Michigan law, pursuant to MCL 500.3107.*" (App at 69a (emphasis in original).) Farmers recognizes that it is required by statute to pay "all reasonable charges incurred for reasonably necessary" medical treatment – an obligation Farmers fully satisfies through PPOM. MCC/MCS point to no evidence that insureds receive any different scope or quality of care under the PPO Option than they would receive outside the network. (App at 68a.) In fact, in the five-year history of the Option, no insured has ever complained or asserted that he or she is not receiving all reasonably necessary medical treatment through PPOM. MCC/MCS bring this action not because they truly believe the Option is bad for insureds, but because they think it is bad for their own bottom lines.

I. COUNT 2 OF MCC/MCSs' REQUEST, AMENDED PETITION, AND PETITION FOR REVIEW IS NOT PROPERLY BEFORE THE COURT.

In their brief, MCC/MCS insist that Count 2 of their Request, Amended Petition, and Petition for Review remains alive for purposes of this appeal. (MCC/MCSs' Br at 38 ("[T]his case continues to concern both the count involving provider rights [Count 2, which alleges a violation of § 3157] and the count involving the rights of insureds [Count 1]."); *see also id.* at 30-31 (addressing merits of Count 2).) However, MCC/MCSs' claims in Count 2 are not

properly before this Court. Under Michigan law, an appellee must file a cross appeal if he wishes to attack part of a final judgment in order to enlarge his own rights or reduce those of his adversary. *See McCardel* v *Smolen*, 404 Mich 89, 94-95 (1978) (refusing to consider defendant-appellee's attack on injunction without cross appeal); *accord United States* v *Neal*, 93 F3d 219, 224 (CA 6 1996). As the Court in *McCardel* explained, "an appellee . . . may urge any mater appearing in the record in **support** of a judgment, **but he may not attack it** even on grounds asserted in the court below, **in an effort to have this Court reverse it,** when he himself has not sought review of the whole judgment, or of that portion which is adverse to him." *Supra*, at 95 n 6 (citation omitted). In this case, the Court of Appeals ruled in MCC/MCSs' favor only on Count 1, and rejected Count 2 on the merits. *See Michigan Chiro Council v Commissioner*, 262 Mich App 228, 246 n 12; 685 NW2d 428 (2004). MCC/MCS have not filed a cross appeal of the court's ruling on Count 2. Therefore, while they are free to argue for affirmance of Count 1 (which Farmers has appealed), this Court is without jurisdiction to consider Count 2.

In any event, Count 2 is no longer viable following this Court's decision in *Advocacy Org v Auto Owners Ins Ass'n*, 472 Mich 91 (2005). (Farmers' Br at 8-9.) That decision held that § 3157 does **not** entitle care providers to receive their "customary" fees for treating insureds under the Act.[1] (*Id.*) But this is the precise allegation MCC/MCS make in Count 2. (App at 9a ("[T]he effect of Farmers' program is to force providers such as chiropractors to either accept a rate less than the **customary** charge or be excluded completely . .

[1] MCC/MCS incorrectly argue that *Advocacy Org* was a plurality opinion. (MCC/MCSs' Br at 38.) Instead, all six justices who sat for the case joined the majority in holding that § 3157 does not create an entitlement for payment of "customary fees." *See Advocacy Org, supra* at 95 ("Because we agree with the Court of Appeals resolution of this issue, and the others presented to it, we affirm.").

. ."), 53a, 94a.) *Advocacy Org* thus destroys the sole premise on which Count 2 is based. The claim is therefore not viable even if it had been properly appealed.[2]

II. MCC/MCS DO NOT HAVE STANDING TO ASSERT THEIR CLAIMS.

MCC/MCS concede that they must establish standing by the "general factual allegations" in their complaint, in this case the Petition for Review. (MCC/MCS at 37.) However, Count 1 of the Petition for Review contains not a single allegation of injury to MCC/MCSs' members. (App at 89a-93a.) Despite this, MCC/MCS claim they have standing anyway because the interests of their members are allegedly aligned with those of no fault insureds. (MCC/MCSs' Br at 39.) In fact, however, the Petition for Review alleges no such relationship. (App at 89a-93.) Moreover, the law is clear that a party cannot establish standing based on the alleged injuries of third parties. (Farmers' Br at 12.)

MCC/MCS have also failed to establish other essential elements of standing – namely, germaneness and lack of conflicts – as articulated by the U.S. Supreme Court in *Hunt* v *Washington*. (Farmers' Br at 10-11.) With respect to germaneness, MCC/MCS claim that their organizational purpose includes "promoting and protecting the public health." (MCC/MCSs' Br at 41.) However, they did not make such an allegation in their Petition for Review, the only thing that really counts for standing purposes in this case. [3] (App at 83a-98a.) Second, MCC/MCS have not demonstrated that they are sufficiently free of conflicts of interests to bring

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[2] MCC/MCS try to avoid this result by attempting to recast the substance of Count 2 in their brief. Rather than state, as Count 2 actually states, that the PPO Option denies providers their customary fees, MCC/MCS claim they have "essentially" always been saying that the PPOM rate is not **reasonable**. (MCC/MCSs' Br at 39.) But this creative effort fails. This Court and the Court of Appeals in *Advocacy Org* made clear that there is a difference between a reasonable and a customary rate. And under § 3157 a rate can be reasonable even if it is not the provider's customary rate. In this case, despite their effort to recast Count 2 in their brief, MCC/MCS have **never** alleged that payment to providers under the PPO Option is not reasonable. Their only claim has been that it denies them their customary rate, which is not viable after *Advocacy Org*.

[3] Nor have they explained what protecting the "public health" has to do with their claim in Count 1. (MCC/MCSs' Br at 41; App at 89a-93a.) They do not allege that the PPO Option presents a danger to the health of insureds. (*Id.*)

this suit. (Farmers' Br at 14-15 (discussing cases).) Although they claim that some of their members signed on with PPOM as care providers before the Option was being offered, they do not dispute that many of their members **remain** signed on and are thus **benefiting** from the Option at the same time MCC/MCS are trying to kill it.[4] (MCC/MCSs' Br at 42.) Thus, for these reasons as well, MCC/MCS lack standing to bring their claims.[5]

III. THE CIRCUIT COURT APPLIED THE WRONG STANDARD OF REVIEW.

MCC/MCS maintain this Court and others must apply a *de novo* standard of review to any decisions by the Insurance Commissioner that involve the interpretation of the No Fault Act. (MCC/MCSs' Br at 19-20.) But this is erroneous. It is important to remember that this case arises from a specific request for relief filed by MCC/MCS – namely, a Petition for Review of the Commissioner's decision to deny their request for contested case proceedings. (MCC/MCSs' Br at 83a-98a.) As the Court of Appeals recognized in *Brandon*, the only legal issue in such a case is whether the Commissioner has the authority to decide whether or not to institute case proceedings. *See* 191 Mich App 257, 263-65; 477 NW2d 138 (1991). Once that question is answered in the affirmative, courts have no authority to review the substantive correctness of the Commissioner's decision to grant or deny the request. (Farmers' Br at 16-19.)

This Court recently affirmed the broad scope of the Commissioner's authority in *Rory* v *Continental Ins Co*, 2005 WL 1793572; 473 Mich 457 (July 28, 2005). In that case, the trial court refused to enforce a one-year limitations period in an insurance policy on the ground that the provision was unreasonable, but this Court reversed, holding that the provision had to be

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[4] This conflict of interest is a bar to MCC/MCSs' standing on both Counts 1 and 2.

[5] MCC/MCS contend that this Court should reach the merits of their claims anyway on the theory that they are allegedly likely to arise again in other cases. (MCC/MCSs' Br at 43.) However, only an insured would have standing to bring a claim like this and that is not at all likely to occur. The Option has been on the market for five years without any kind of controversy or complaint being initiated by an insured.

enforced as written. *Id.* at *1. In reaching that holding, the Court quoted from MCL 500.2236(5), which grants the Commissioner the authority to approve or disapprove insurance policies: "Upon written notice to the insurer, the commissioner **may** disapprove, withdraw approval or prohibit the issuance, advertising, or delivery of any form to any person in this state if it violates any provision of this act, or contains inconsistent, ambiguous, or misleading clauses, or contains exceptions and conditions that unreasonably or deceptively affect the risk purported to be assumed in the general coverage of the policy." *Id.* at *6 (emphasis added). In light of this broad language, this Court stated as follows: "Clearly, the Legislature has assigned the responsibility of evaluating the 'reasonableness' of an insurance contract to the person within the executive branch charged with reviewing and approving insurance policies: the Commissioner of Insurance. The statute **permits, but does not require**, the Commissioner to disapprove or withdraw an insurance contract if the Commissioner determines that a condition or exception is unreasonable or deceptive." *Id.* (emphasis added). The Court therefore found that the trial court had erred in conducting a *de novo* review of the policy. *Id.* at *7.

The same reasoning applies in this case. Section 2236(5) is the same provision of the Insurance Code that the Commissioner relied on here as authority for his decision to deny the request for contested case proceedings. (App at 66a ("[T]he Commissioner has authority pursuant to 2236 of the Code . . . .").) That provision states, in the same sentence this Court relied on in *Rory*, that the Commissioner "**may** disapprove, withdraw approval or prohibit the issuance, advertising, or delivery of any form to any person in this state **if it violates any provisions of this act,**" meaning the Insurance Code, which includes the No Fault Act. MCL 500.2236(5) (emphasis added). As in *Rory*, the legislature's choice of the word "may" is a clear indication of its intention to "assign[] the responsibility for evaluating" the policy's legality to

the Insurance Commissioner. *Supra* at *6. Thus, only the Commissioner has the discretion to decide whether or not to approve a policy under the Act. The lower courts' *de novo* review of that decision was therefore improper and must be set aside.

IV. EVEN IF THIS COURT WERE TO REVIEW THE MATTER *DE NOVO*, MCC/MCS HAVE NOT SHOWN THAT THE PPO OPTION IS ILLEGAL.

A. MCC/MCS cannot escape the essential holding of *Tousignant*.

MCC/MCS go to great lengths to distinguish this Court's holding in *Tousignant* v *Allstate Ins Co*, 444 Mich 301; 506 NW2d 844 (1993). (MCC/MCSs' Br at 24-26.) The thrust of their argument is that because health insurance benefits are not PIP benefits, *Tousignant* is of no help to Farmers. (*Id.* at 26.) But there is nothing talismanic about "health insurance benefits" that makes them, but not PIP benefits, consistent with a system of managed care. Instead, MCC/MCS ignore the fundamental reality that links this case with *Tousignant*: that when an insured voluntarily chooses to coordinate coverage and thus receives medical benefits for automobile injuries through an HMO or PPO, the insured is making use of managed care under the No-Fault Act. This Court held that the Act allows such use of managed care, and the concomitant limitations on the choice of physicians and facilities, so long as it is the result of a voluntary agreement by the insured, as it is here.[6] *See Tousignant*, *supra* at 310.

MCC/MCS argue that the No Fault Act is intended to be a "fee for service" system, which allegedly requires an unlimited choice of providers for insureds. (MCC/MCSs' Br at 22-23.) In support of these assertions, MCC/MCS point to one – and only one – case, *Morgan* v *Citizens Ins Co*, 432 Mich 640; 442 NW2d 626 (1989), which they claim stands for

[6] MCC/MCS claim that insureds who elect the PPO Option are "contracting away" their essential rights under the Act. (MCC/MCS Br at 31-32.) However, under the PPO Option the insured gets reimbursed for all reasonably necessary medical services, as the Act requires, and also enjoys a choice of providers. First, the insured has a choice at the beginning about whether to elect the PPO Option. Second, after electing the Option, the insured can decide whether or not to stay within the network for treatment. If he stays within the network, he can select from more than 30,000 physicians who are members of PPOM. (Farmers' Br at 4.)

the proposition that managed care is inconsistent with the No Fault Act. (*Id.* at 24.) But that case is readily distinguishable. In *Morgan*, the Court rejected the effort of an insurer to **impose** a limited choice of physicians on the insured by refusing to pay for treatment at nonmilitary hospitals.[7] *Id.* at 646, 648. In contrast, here, as in *Tousignant*, everything is voluntary.

B. MCC/MCS continue to mischaracterize the pertinent issue facing this Court.

MCC/MCS claim that "[t]he No-Fault Act does not permit managed care, especially the PPO Endorsement, until an **express provision allowing managed care** is enacted." (MCC/MCSs' Br at 35 (emphasis added).) But that is an incorrect statement of the law. This Court made clear in *Cruz* that just because something is not expressly authorized by the Act does not mean it is prohibited: "The Court of Appeals . . . found that EUOs were precluded in the automobile no-fault insurance context because they were not mentioned in the act. In our judgment, the Court was in error. EUOs, or other discovery methods **that the parties have contracted to use**, are only precluded when they **clash with the rules** the Legislature has established for such mandatory insurance policies."[8] 466 Mich at 598 (emphasis added).

MCC/MCS speculate that if existing law permits the Option, "nothing would prevent Michigan no-fault insurers from dropping their indemnity policies . . . to offer only managed care." (MCC/MCSs' Br at 32.) But that hypothetical is not before the Court. As the

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[7] The same is true of the cases cited by amicus curiae Coalition Protective Auto No Fault. (CPAN Br at 10-12.) The insurers in *Hoffman*, *Munson*, and *Mercy Mt. Clemens* sought to **impose** fees on providers that were less than they customarily charged. In contrast, under the Option, care providers voluntarily choose to join PPOM.

[8] MCC/MCS continue to place great reliance on 1993 PA 143 ("Act 143"), (MCC/MCSs' Br at 26-32), but that reliance continues to be misplaced. First, Act 143 proposed many changes to the No Fault Act, only some of which dealt with managed care. It is thus pure speculation to say that Act 143 was rejected because of its managed care provisions. Next, the PPO Option is fundamentally different than Act 143's managed care provisions. Under Act 143, insurance companies could have **imposed** managed care on insureds where benefits were under $300,000, and managed care was **required** where benefits exceeded $300,000. Finally, Appellees' argument proves too much. If the referendum on Act 143 means that managed care is incompatible with the No Fault Act, such that insureds' statutory entitlement to medical benefits cannot be satisfied through systems of managed care, then *Tousignant* was wrongly decided and every no-fault policy in Michigan coordinated with an HMO or PPO is illegal.

facts stand, Farmers is offering the Option to its insureds as one of several available endorsements to a standard policy. This case thus presents managed care only as a voluntary choice, which was critical to this Court's holding in *Tousignant* that managed care through coordinated coverage does not conflict with the Act.[9] This Court can decide whether an insurer can offer a strictly managed care policy if and when a case like that arises.

MCC/MCS also assert that the PPO Option conflicts with the legislature's intent in passing § 3109a, the provision of the No Fault Act which permits coordination of coverage. (MCC/MCSs' Br at 26-27.) They argue, without authority, that the purpose of that provision is to shift costs from the no fault regime to coordinated coverage, and that the Option conflicts with that purpose by making no fault policies more attractive to insureds. (*Id.*) However, the purpose of § 3109a was **not** to shift costs to coordinated coverage but to eliminate duplicate coverage and allow an insured to save money by receiving no fault coverage through his or her health insurance policy. *See LeBlanc* v *State Farm Mut Auto Ins Co*, 410 Mich 173, 194, 196-97; 301 NW2d 775 (1981). Far from being in conflict with those purposes, the PPO Option furthers them by providing insureds with reduced premiums in exchange for participating in PPOM.

C. There is no merit to MCC/MCSs' argument that the Option is involuntary.

MCC/MCS claim the PPO Option "imposes" managed care on no fault insureds and "forces" providers to accept less than their customary fees. (MCC/MCSs' Br at 5, 31, 38.) But this is ridiculous. No insured or care provider is, or could be, forced by Farmers to participate in PPOM. Insureds and providers decide on their own whether they think the benefits of participating outweigh the costs. What really offends MCC/MCS about the PPO Option is that they believe it presents them with a choice of either joining PPOM and accepting reduced

[9] MCC/MCSs' suggestion is no different from a suggestion that, under *Tousignant*, an insurer now has free license under the No-Fault Act to offer only coordinated policies.

rates or staying independent and having to compete with PPOM physicians who are accepting reduced rates. But as this Court emphasized in *Cruz*, "[t]he purpose of Michigan's no-fault system is to provide **victims** of automobile-related accidents with assured, adequate and prompt payment for economic losses." *Cruz*, *supra* at 164 (emphasis added). There is no authority for the proposition – and MCC/MCS cite none – that the purpose is really to make sure physicians can charge whatever they want for their services.

D. The PPO Option does not conflict with § 3157 of the Act.

MCC/MCS stand by their claim that the PPO Option violates § 3157. (MCC/MCSs' Br at 30.) Assuming *arguendo* that this Court has jurisdiction over the claim, and that it survives the Court's holding in *Advocacy Org*, the claim nevertheless fails on its merits for two primary reasons. First, under § 3157 a care provider may charge a "reasonable" fee, not to "exceed the amount the [provider] customarily charges for like . . . services." MCL 500.3157. This provision merely places an upper limit on the fees providers can charge for their services. *See* MCL 500.3157; *Advocacy Org*, *supra*. Nothing in § 3157 prohibits a provider from voluntarily agreeing to accept a fee that is less than this upper limit. To the contrary, such agreements directly promote the policy of the Act by holding down the costs of medical care. Second, MCC/MCSs' arguments ignore the voluntary nature of the PPO Option. It is up to each provider to decide for itself whether the benefits of participating in PPOM – in particular, a ready pool of patients – are worth the tradeoffs. Any provider who thinks PPOM's rates are unfair need not join. Similarly, any non-PPOM provider who is uncomfortable with the payment arrangements that apply when PPOM participants seek treatment outside the network need not provide services. Involvement with PPOM is therefore strictly voluntary whether the provider joins PPOM or chooses to remain independent.

E. The PPO Option is not illusory or deceptive.

Although they have never argued the issue before, MCC/MCS now pick up the banner and claim the PPO Option is illusory and deceptive for the reasons stated by the Court of Appeals. (MCC/MCSs' Br at 35-36.) Specifically, they claim insureds are not likely to understand that an insured who selects the Option will have a limited choice of physicians and will not be eligible for other Farmers' rate reductions, including the "other insurance" credit and the so-called E7143. (MCC/MCS Br at 36.) However, even the one-page description of the Option relied on by the Court of Appeals states that "[t]he [Option] requires the insured to choose a physician from our captured network."[10] (App at 2a.) The Option also explains that an insured who chooses to go outside the network will "be subject to a $500 deductible" and will only be reimbursed "the amount which would have been payable had [he or she] used the services, utilization review, and fee schedules of the designated PPO." (App at 44a.) Finally, the one-page description of the PPO Option states that "[p]olicyholders who elect the [Option] will receive a 40% reduction on their PIP rate. . . . **The E7143 will not be allowed if this option is selected. The other insurance credit will not be allowed if this option is selected."** (App at 2a (emphasis added).) In light of these disclosures, it is absurd for MCC/MCS to claim that the typical insured who selects the Option might be confused about what it means.

CONCLUSION

For the reasons discussed above and in Farmers' opening brief, Farmers respectfully requests that this Court reverse the decision of the Court of Appeals and reinstate the Commissioner's Administrative Orders.

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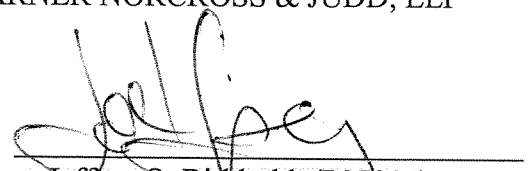
[10] Insureds are also required to sign a disclosure stating that they "agree to use the participating Preferred Provider Organization (PPO) for medical care and rehabilitation," (App at 45a), and the Option endorsement itself states that "[m]edical service will be provided by a Preferred Provider Organization . . . designated by [Farmers]," (*id.* at 44a.).

Dated: September 16, 2005

WARNER NORCROSS & JUDD, LLP

By: 

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